



# KIDS Plus IMMUNIZATION RECORD REQUEST FORM



## PATIENT INFORMATION

LAST NAME:		FIRST NAME:	MIDDLE NAME:
DATE OF BIRTH:	ADDRESS:		
CITY:	STATE:	ZIP CODE:	

## REQUESTER INFORMATION

REQUESTER LAST NAME:		REQUESTER FIRST NAME:	
RELATIONSHIP TO PATIENT (SELF, MOTHER, FATHER, ETC):			
ADDRESS:			
CITY, STATE & ZIP:		PHONE:	FAX:
SIGNATURE OF REQUESTER:		DATE:	

**PROPER IDENTIFICATION IS REQUIRED FOR RECORD RETRIEVAL (i.e. DRIVER'S LICENSE). PLEASE ATTACH A COPY OF YOUR IDENTIFICATION WITH YOUR REQUEST.**

### For Official Use Only

APPROVED BY:	DATE:
FORM OF IDENTIFICATION:	ID #